AZ Medicaid Outpatient Workgroup Meeting

August 31, 2004
10:00 AM to 12:00 PM
AHCCCS 701 E. Jefferson St. – 3rd Floor - Gold Room

Meeting Hosted By: Sara Harper, AHCCCS

Attendees:

(Based on sign-in sheets)

AHCCCS	CARE 1ST ARIZONA	MCP/Schaller Anderson
Dick Azzi	*Anna Castaneda*	*Pam Hydrick*
Howard Beam	*Michael Boisseru*	*Cathy Jackson-Smith*
Cia Fruitman	**CMDP**	**PHP**
Sara Harper	*Amanda Worth*	*Greg Lucas*
Dora Lambert	**COCHISE**	*Don Lopez*
John Murray	*Marcia Goerdt*	*Pat Lapp*
Lori Petre	**DES**	**PHS**
Mark Renkel	*Marcella Gonzales*	*Mary Kaeler*
Mike Upchurch	*Pat Fizer*	*Marcia Leblanc*
AMERICHOICE	**HEALTH CHOICE AZ**	**UFC**
Vanessa Wright	*Joan Toaland*	*Kathy Steiner*
Brenda Reininger	*Lorie Owens*	**YAVAPAI**
APIPA	**INC**	*Becky Ducharme*
Alexia Cathers	*Schemell Moore*	
Sharon Zamora		

1. Welcome (Lori Petre)

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We are going to walk through the agenda and what we would like to accomplish with each item. The first handout in your package, and in the email that was sent out, is the current timeline. We are still tracking for the most part to the dates indicated. We do have a draft system design proposals, which are the three documents that we are going to walk through today. Applications is still working diligently to finalize these. We hope to do so within the next couple of weeks so that by the time we have the next meeting we will have finalized design documents that we can walk through, and to hi-lite the things that were changed and updated.

The workgroup meeting for 8/25 was obviously rescheduled to today. The next one is scheduled for 9/15, and the very last agenda item talks about upcoming meetings and how we would like to handle them.

We want to remind everyone about the website again and workgroup email address. We also want to encourage you to send questions, comments and issues on anything or examples that you would like to see walked through or formulated, to the web email address and we will get them tracked right away.

What we are going to do is walk through these (System Proposals) first. We have one set of questions from Sharon with APIPA and I'm sure others have questions also. It may be that we are not prepared to answer all of them today, but we are going to go through them, and if there are questions that can't be answered today, we will make sure they get documented and we will do a formal response. We will start with the system proposal

John Murray (Review of System Proposal)
There is not much change from what we had a few weeks ago. We have given you a total of eight table extracts. You are familiar with the layouts that you currently get from the server. You pull the reference files and provider files onto Reference01 and Reference02. We are going to create a third file called Reference03, which is going to also be put out on the server. On it there is going to be 8 extract files supporting Outpatient. The first one on page 48 is the header, which is basically the date of the file. The second one is a record type N1. You will see it is very similar to a record that you currently get on the Reference01 extract. It represents the procedure code effective begin dates. All the information on this is pertinent to Outpatient. How many of you have access to PMMIS record screens? Looks like a couple of you. In the document, I get into great detail on those screens and I wasn't sure how pertinent it was to everyone here. So, we want to look at those layouts too because they do tie into the extract. On page 9, the document will start with the screen layouts. We are going to flip back and forth between pages so that you can see the relationship. On page 10, the main menu for the procedure codes, you will see the first three items are hi-lited. Item 4, Correct Coding Cross Reference, items 24 and 25 are the procedure indicators and the OPSF price. The correct holding extract is a table that we currently receive information from CMS, the CCI codes which we place on a claims table. We realize for this process we need to take that information in a slightly different format and put it on the cross reference table, which is going to be CCI codes. Basically it is going to give a listing of all the procedure codes that are bundled according to the Medicare rules. The information that we get currently for the CCI codes is placed on the encounter tables. We understand there is a difference in the codes that are going to be listed for the Outpatient versus those that are there for the 1500's, but we haven't determined that yet. Once we have determined if that actually is different than the information that we currently get, there is a possiblity that the layout on this table that we have described in the cross reference will change slightly. We are going to put an indicator on there to specify the source. So, we get the CCI codes now and we are going to put those on the table and we will put the source as an indicator. If we find out there is other information pertinent just to Outpatients we will store that on the same table, but we will give it an indicator to indicate that the source is for the Outpatient codes only. Again, so far we have not been able to go into great depths in the little bit of analysis that we have done. We haven't seen any real differences between the two sets of codes. I was hoping that maybe someone could give me some information and say "yes, there is a difference and we know what it is." If not we will just continue until we find out exactly what it is and then we will confirm in the latest document that we send you. We just want to remind you that it is a draft and it is almost final or set in stone, other than that single table. We

just have to figure out whether there is an indicator or not. We will go through the file layout for each of these. On page 12 it says the OPSF price, corresponds to page 49, the price record we are going to send you, the N2 record. Basically we are sending you the county. For all intents and purposes it is the value that is in there is 99. The beginning and end date the actual price itself. That is very similar to the layout that we currently send you for the MAC prices, but we decided we are going to put this in a totally different table so that it is split off and then we can maintain it separately without any overhead on the existing process. On page 15 you will see error 127, which is the procedure OP indicators and values. Again, this is very similar to the extract record we will be sending to you. Basically this is the information straight from the Database in its entirety and you will get everything that we have.

Question HP: We are still having a lot of problems with encounter editing and limits Are we going to copy the limit tables from the existing one?

John: No we are not. We are going to have separate limits for the OPSF record layout.

Sara: We are looking at units and limits. It has not been completed, but it is on our list to do.

ACTION ITEM: Sara to follow up on limits issue.

Lori: Can we put a laundry list together as to what we started and we can add to it with periodic updates.

ACTION ITEM: Sara to provide a list of what we've started.

Comment HP: I noticed that you were working on overriding the units.

Sara: The units are going to have a different meaning for Outpatient. Historically units have not meant too much for Outpatient on the FFS side especially because basically it was a Cost to Charge ratio. The units' field, as long as it is populated, hasn't been looked at too much. There are some edits I think that have been on and there are some limit issues with certain procedures that go over 999. So, you do have to look at it because it looks like a double bill because you want to report on the unit. Units are going to take on a new meaning with the fee schedule and we are writing the FFS billing requirements in the program manual. We have to get everyone's input. Units are going to drive payments. So between a 1 and a 6 in the unit column can be big bucks. We have to focus on that.

Question HP: The current unit process is setup on a daily and weekly max. So this is for the bill period?

Sara: Yes. We will talk more about the units issue later. We have a survey we are going to be doing.

Question HP: Where do you go for reasonableness?

Cia: They are looking at units in particular lab and radiology. We are writing billing policies and we'll share them with you so you know what we are instructing hospitals to do. We will create reports. What we want to do is turn the edits on sooner.

Howard: We will probably turn them on soft at first.

Cia: We want to start monitoring what the hospitals are billing, and doing a lot of work with the hospitals to make sure they are billing correctly. We are figuring in six months we will have some edits in place and start monitoring, we know we won't pay them January 1st, but we can work with the hospitals for correct billing. We can work with the hospitals to do provider education on correct billing because if they don't bill correctly they are not going to get paid correctly.

Sara: The units are driving this. It is very important that they are accurate, and from what we are finding in our units fields, we question them currently.

Howard: We are changing the encounter system to start capturing on the UB the same way that claims captures dates of service at the line level, and that should help clear up some of the unit issues. Now instead of having just one 25-day range of dates and then having procedures where you can't tell that this was performed on day one and day fifteen, we'll be able to see that now because at the line level we'll have more procedures that happened on January 15th than happened on January 30th. So that way we'll be able to tell some of that in point in time when this goes in.

John: Anymore questions on this?

Question HP (Teleconference): Can you review the questions or a summary of what was being asked?

Sara: The questions were on the units' field and how AHCCCS is going to edit and pay based on units for the current issues going on. After all the discussion, Howard had said lets hold the unit discussion until he gets to encounters because he is going to talk about that specific issue when he goes through the encounter pages. So we won't repeat everything that was discussed because that is part of Howard's encounter section when he talks about that part of the analysis.

John: I'll continue on with the reference presentation. Again, anymore questions on this layout? We'll go onto the next item. On page 17 you'll see the correct holding cross reference, which I briefly mentioned at the beginning of my discussion. Basically its procedure, which we call a correspondent procedure. When we put this draft together we were a little ignorant on the fact that this would be coming from the CCI codes so we were going to end up renaming it so that it's more meaningful. The name of it will be the CCI code and the one on the left with the procedure code related to it. There are some minor changes to this layout as I mentioned earlier. Depending on the source of the code, whether they are specific to Outpatient or whether they are more general for UB's, we'll specify that on this field layout with an indicator. We should be getting out a new record layout to you within a week or so.

ACTION ITEM: John to get a new record layout to health plans.

We want to get some more information before we make that final change. The corresponding record for that is on page 49. Then we get to page 20, which is the encounter claims reference menu. Actually there are no changes to that menu. Then we get to page 21, and there are five items added. Number 48 with the limit override modifier screen and then the next one I'll talk about is 53, multiple surgery exception table. I'll talk about 55, 56 and 57, which are the OPSF bundled rate driver table, bundled revenue codes and the override modifier action codes. On page 24, the bundled revenue codes are basically the codes, which again I can't go into how they are going to be used in encounters. Howard will be able to explain that, as to how they are going to be referenced in the new changes he is putting in. As far as the tables are concerned and the information you are receiving, you are going to be receiving all the codes with effective begin and end dates. Again, the record layout for that is type N4 on page 49. On page 25 it shows that the OPSF bundled rate driver table, and again Howard will explain exactly how encounters will utilize this table. The record layout for this is also on page 49, and is actually N3. On page 30, you have the multiple surgery exception table. These are the codes, we wont' say the description on each file layout, we are going to keep it as small as possible by sending you the codes and the effective begin and end dates. The record layout for this one is actually N6. On page 31 we have the limit override modifiers. Again, it's pretty much a cross reference between the modifier codes and the action. We are going to send you everything on this table on the record layout for that. On page 40 it shows the multiple surgery exception table. Again, it is straightforward. It is a code of the beginning and end date. The record layout for that is N8. On page 45, section 6.25, there is an area there that is currently not complete, but we have to determine where we are getting our source to load the CCI codes. Once we determine that, we will fill that information in in the final draft. That concludes the record layout that you are going to receive. Are there any questions? If not, Howard will now present encounters.

Howard: Good morning, my name is Howard Beam and I am the encounter and reinsurance technical teams project lead. I will be talking about encounters and the impact our project will have on that system. The biggest change that we are making has been stressed already. We are going to start needing the units to be more accurate. In conjunction with that, Brent has made it a requirement of this project that we begin collecting begin and end dates of service on the encounters at the line level to facilitate a lot of the service unit issues that we are currently having. Cia tried to sneak that in earlier in the HIPAA requirements, but we didn't have the time to modify the databases. The end result is that we will begin collecting and storing line level dates of service. One of the questions I got from Sharon is will service limit edits be taken at the line level? For example, if a client is in a facility for emergency services that carries over into the next day. An example would be someone who was admitted at 10:00 PM on July 10th and discharged at 2:00 AM on July 11th, and the same service is performed on both dates.

Howard: Currently we would have a service begin date and a service end date. So if we had a service limit of one per day, it would be very difficult for the system to tell whether you are exceeding the limit or not. It is not a full day in time. It is only four or five hours, but it is two separate days. Now, when we start capturing the fact that one is on July 10th and the procedure is performed at the line level with that date range of July 10th through July 10th, and then July 11th through July 11th for the second procedure. That helps to clear up some of that large boulder size granularity on our service editing.

Question HP: Are the service facilities going to be trained to start billing that way?

Howard: Unfortunately that is a Brent question and he isn't able to be here today. I am assuming that will come under the training and billing manual that Cia and her people are putting together. They will need to start billing these things and that the units and dates of service at the line level will become very critical.

Comment HP. On the UB form itself has a service date, one date at the line level. It doesn't have the "to/from."

Howard: Right. In which case we are going to assume since you can only report that one. I'm not sure on the 837 if it has the service begin date and service end date.

HP Reply: The 837 doesn't allow for it. It allows for the from date at the line level.

Lori: That is a UB04 change and it only allows for one on the hard copy form.

Howard: I was not aware of that and that is not in any of the specs that Brent has given me. I was just starting to do a walkthrough between what is being requested and what is available on the 837.

Comment HP: We ask the hospital that they submit the 837I to us to include that at the line level and they were not allowed to do that with the current 837. They are only allowed to pass that one date basically at the line level.

Howard: Lori is saying that you are absolutely correct. It is not accommodated on the current form and we need to verify the electronic 837 format. I guess that will become something that Brent and I will have to hammer out. I was under the impression from his requirements that he had given me that we got both of them. OK. That becomes my first big question for him once we get out of this meeting

ACTION ITEM: Howard to ask Brent about the above.

Comment HP: We now have a line item outpatient bill. If they are in the Emergency Room for 18 hours and there is 27 drugs administered and maybe some more than once. Each drug will have to be listed. I've never seen it like that on paper.

Lori: The paper claim does accommodate it. Hawaii does line item processing in this manner.

Comment HP: This becomes a massive paper claim. Only accommodating if you have electronic billing. When we move to this new billing process, you will collect this data and then you will get the information that you asked for. Are we preempting this collection of data? Are we going to start requiring in a case where someone is in the emergency room for 18 hours and it crosses over a day and they receive a drug on the first day and on the second day. They receive 27 drugs each day, are we going to end up with 54 line items on the encounter?

Howard: That is they way they are intending for this to work. It is a big change from the paper formats so there is going to be a lot of training issues involved. Claims will be doing the training.

Cia: Medicare is making hospitals do this now. They want to see it on every line. Hospitals are somewhat used to this now, a separate line for every service. For what it's worth, we see how big some of these get. On the claims side, we have seen some large periods of service. Limit the size of these bills so that we don't end up with a 10-month Outpatient bill with 20,000 lines on it. The policy at AHCCCS is going to change to start requesting that we actually use the initial bill, interim bill and ending bill types so that we are able to report that ten month encounter or claim as an initial bill for the first one, interim bills for each of the intervening months and then the final one coming in as the final bill, and to limit the date span to roughly a month or so. We are going to be putting this in the policy manual on the claims side.

Howard reiterated the above.

Howard: Some of the systems have limits to 99 lines. Our system has a limit of 99 lines per UB. One of the requirements for HIPAA is 999 lines for UB. That is a massive system change. You think "Oh we just have to change it to be three bytes long." Well it is larger than that. Our software, the way that it works has a table limit size, which means we can only have so much of a block of memory allocated to store the data. The way our system is currently designed, it reads in those 99 lines in the driver program and then passes all 99 lines down to each of the editing modules for Recipient, Provider, Procedure, everything. We can do that because that is a block of code that is X big. Now it is X times nine and when we try to compile the programs in that mode, the system will not compile them because it exceeds the amount of memory that the software can handle as one contiguous block. So, we've got a major redesign to do that. That is why we implemented HIPAA without the 999 line requirement because we know that it's a massive change for us. Currently the analysis that we performed was that there were not a large number over 999 line UB's coming in. In fact, out of the respondents to the surveys that we sent out, I think we had four plans that averaged maybe sixteen a year. Out of however many million encounters come in, it wasn't deemed at that point and time a worthwhile effort to make that change, but with this change in the billing methodology that we are using, it is beginning to look like in the long run that we may have to do something with it.

Lori: We'll have to reevaluate that.

ACTION ITEM: Lori to reevaluate system changes regarding the 999 line requirement.

Howard: We are aware of the problem. For us it is as big of a stumbling block as for anybody else because it is going to require some major system changes for us to overcome it.

Question HP: Is the encounter editing and claims editing going to be identical?

Howard: The intent is "yes." That is what we are trying to do. I still have a few outstanding issues that I am waiting for some answers from Brent on, but that seems to be the approach that is being taken, which is that we will have some consistent editing across the encounter end claims world.

Question HP: Will this be for Outpatient or for everything?

Howard: For the new Outpatient project initially. Eventually they want to get to where everything is that way. We are limiting it initially to just this new Outpatient Fee Schedule Payment system.

Sara: We are still having conversations on that. The idea is to make them similar because most plans have indicated that they want to follow this fee schedule. If you are going to follow it, you'll need to follow it the way it is implemented for AHCCCS. Otherwise you can come up with your own, but there are several conversations that haven't taken place yet. Based on the conversations that have been heard by Kari Price and her folks, the plans that have said, "yes, we are on board and we want to do what you do." That is where we are taking that. Lets make the initial edits as similar as possible.

Question HP: I just want to clarify that because if you are going to do table maintenance for us, we need to know that there is at least one process through the edits. Somewhere there needs to be an override process on encounter side. Not just turn it on soft or hard, but sometimes override for things that still have to get to (inaudible). We still have age problems and unit problems for different programs. (Inaudible) Can we look at what is outstanding?

Howard: Please email Brent with your concerns. Make sure that he is aware of them.

Lori: Actually, email the workgroup and then we'll monitor and track them.

Howard: Some of the other questions that I had are "are you stating the plan is to report billed units, reduced units, and paid units in separate fields within the CAS segment at the line level versus the header?"

Howard: My understanding is yes. That is the way we want to do it. That ties in with the whole way that this system is going to work. Right now I realize that is a big change for everyone because what we are seeing on the 837's is at the header level is where you are reporting this information. You are not breaking it down at the line level.

Howard: Will service limit edits be applied to paid units versus billed?

Howard: Yes, that is one of the requirements. That just makes sense because what you are billed and what you paid, you are reporting what you paid so we should be editing based on what you paid. We should not deny something based on what the provider billed you if you already have cut that back and you report that cutback, etc. to us. So in other words, if you were billed three units and you only allowed two units and you report it that way to us as two units paid, we will be editing versus the two units that you paid for correctness basis service limits etc. Your system has already weeded out the fact that this is something that you are only going to cover twice a day, or whatever.

Question HP: The infamous near dup pend logic does not include the discharge hour. How will this affect editing on claims that have the same date but different admit and discharge hours? In other words, two ER visits on the same day.

Howard: That is one of the things that I am talking with Brent in detail about is our service limit and near dup editing. The requirements that I was given is dup and near dup edit changes are required for encounters. They want us to continue to near dup pend logic, which includes admit date, admit hour and discharge date. Clean up the dup and near dup logic to include admit time and make dup check the same for encounter and claims to ensure that the hospital is able to submit these in the same manner whether it is coming as an encounter or as a claim. We are trying to bring these in sync.

ACTION ITEM: Howard to follow up with Brent regarding service limit and near dup editing.

Howard: Do we have any other questions? We are going to have some new encounter editing. For instance, the operating room and emergency room revenue codes, we are going to now require to have an accompanying procedure code for encounters. Payment status indicator and procedure

modifier relationships are one of the things that we are looking at. One thing that Brent has required is that we are not going to modify the current error reporting processes. So in other words, if you get soft errors and hard errors on an encounter, both will be reported back to you. Sometimes I think that causes a lot of confusion. I've been noticing in the test environment that we'll have stuff fail soft errors in the 837 processing, and it will be reported back and it freaks out people and they are saying why is this failing. When I go and do the research I find it didn't fail, and that it continued on and went to 31/78. It is approved history.

Comment HP: One of the reasons we are freaking is because we see 45,000 pends.

Howard: That was my take on it. Do you really want to see the soft errors? We may want to see them, but I don't know if you guys do.

Comment HP: Sometimes when we are all in sync and we know that something is coming up against our editing scores so that we can see what is happening, but to return all soft edits that you guys look at doesn't make sense. We have had these conversations before.

Howard: One thing that we could do is that the system does have a status for edits called "test." I can suggest to Brent that we start using that for our internal stuff that we want to look at and then we'll only send you hard errors. Then we can look at the stuff in test and only we can see it. We could track the stuff we are testing. The hard errors we would report back and the soft errors would be greatly reduced because a lot of them would get changed to test status so that we can see what was going on and track that stuff that we currently track with soft edits now. Then the only thing you guys would see as soft would be stuff that was scheduled to kick in within the next 90 to 180 days or whatever. That might help that situation a little bit. I've been talking with Brent about that because I have been getting a lot of comments and questions in the 837 testing we've been doing that has been turning out to be soft edits. So I understand exactly what you guys are going through when trying to wade through this stuff because I am having to wade through it in exactly the same manner, to research what is wrong with the system or what is right with the system. Do we have any other questions?

ACTION ITEM: Howard to follow up with Brent regarding the suggestion of using our own internal stuff and sending only hard errors to plans.

Mike: I am the project manager for the claims encounter reinsurance system. The only reason why I suggest that we make sure Brent is aware of all of these items is because a lot of them are business decisions, and he just basically tells me what I have to make the system do. I just need to make sure that he is aware of all the concerns. The first thing is on the claims system proposal. Until I made my developers draw this process out on my board on page six, I didn't get a good grasp of it. Are there any questions about the pricing loop that we go through? I know there was some initial concerns, but haven't heard anything. Since I have Cia and all the developers in one room, if there are any questions on the way this process works, now would be a good time to ask them. I understand it, but as I said, I made them walk me through it on my white board, and after three days of staring at it I finally got a clue. So does everybody feel comfortable with what is happening the way it is walking through the process? OK, I'll take that as a "yes" and go to the next page. On page seven, Howard alluded to the fact that as we bring on these new projects we are trying more and more to bring the claims system and the encounter system in sync. It drives me crazy to talk to my claims people about something and then talk to my encounters people about something and never the two shall meet sometimes. We are trying very hard as we bring on these new projects to try and keep everything synchronized. I think it will make it easier on your part and it certainly makes it easier on mine. So what I am going to do in most of this is go over everything that is going to be changes, and if there is something that you have a question about you can certainaly ask. On page 7 under the claims edit, verify the bill type, values 100 through 187 and 85X for Outpatient/Inpatient critical access hospitals. There was a question brought up as to why only this range and basically it is for the Outpatient hospital rates only and it doesn't really apply to non-hospital facilities.

Question HP: What about SNF's and dialysis?

Cia: The SNF rates will stay as they are and won't be affected. They won't fall subject to this ruling. Anything that takes place in a freestanding dialysis would not apply here. If it was in the hospital it would. Basically anything that doesn't fall within this range will be taken care of by its existing rates.

Question HP: Does that include freestanding ASC's?

Mike: Freestanding ASC's have their own rates. That won't be changed.

Mike: Under claims edits verifying the combination of rev codes, procedure codes and procedure modifiers are valid basically will be now checking all three if they are on the claim or on the encounter to make sure they are all a valid combination.

Question HP: Are we currently getting all the tables?

John: Yes, you are currently getting everything we have up and operational. We will certainly make everyone aware as we start adding the new tables.

ACTION ITEM: John to make sure everyone is aware when new tables added.

Mike: Dropping down to verify that the service limits are not exceeded. This is going to be a new table. So, be aware that we will be looking at something different. On reviewing the existing 1500 edits, these are still being looked at. There has not been any definite decision made on exactly what we are going to cross over with. Under multiple surgeries, there will be a change from what we are currently doing simply because now I think it is 100%-150%, and with the addition of the new table we will be able to pay based on the business decisions that are made 100%-100% as it is outlined to us.

Sara: There will be some exceptions.

Question HP: When done by sequence, how can you know that whatever they choose to consider primary surgery is going to be a numeric sequence? How will we ensure that the primary surgery code as the first code in the line?

Cia: This will be part of the training to the hospitals. The primary surgery will have to be billed first. We will use Claims Clues.

Question HP: To ease the process, can we do it with some kind of modifier to identify the primary?

Sara: We'll look at that.

ACTION ITEM: Sara to check into some sort of modifier to identify primary.

Mike: We'll get back to you on that. Under the duplicate check we have the same problem on the claims side as we do the encounters side with the hour situation. We still have to look at that and see what we are going to do.

Lori: We did get some recommendations on that so that one can be resolved.

Mike: Are there any questions from the documentation? Anything we didn't cover that we need to?

Lori: Do you want to read the questions from emails?

Mike: We did receive some questions last night for the claims process. I think we answered the first one already.

Mike: Why will verification only be on the bill types 100 to 187 and 85X? There again, SNF's and everything will have their own rates.

Mike: Number two. How will claims with bill type 136 adjustment be handled if provider corrects units of service from one to two? Same question could be applied to late charges, bill type 135. Cia's answer is that we have been looking into processing these, but haven't yet finalized details at this time. Basically she is going to work with my programmers and see what we can get worked out to handle this situation.

ACTION ITEM: Cia to work with programmers on how claims with billy type 136 adjustment is to be handled if provider corrects units of service from one to two.

Mike: Number 3. Section identified as frequency service limits is not included in the encounter section. We will adjust that documentation to make sure that we get that in there. Any other questions?

ACTION ITEM: Mike to adjust documentation to include frequency service limits in the encounter section.

Lori: There are also a few on provider reference. Lets read through them all while we have everybody here.

Mike: It stated that procedure max allowed charge will be added for Outpatient CPT HCPCS procedures and that place of service will not be used. How will this affect the new rates in effect new for 2004 that are place of service driven? The coding changes will affect professional services, HCFA 1500's as it also uses HCPC codes correct? There will be no impact on rates, they use place of service because those rates are professional fees whereas these rates are only applied to hospitals. There will be separate rate tables for 1500's and for Outpatient FFS, so it will not affect professional services.

Mike: Number two. The statement that a new table and transaction will be added to cross reference HCPC's to related CPT codes, please explain? To prevent duplicate billing.

Mike: Number three. A process will be scheduled to run annually; new Outpatient FFS schedule updates will be similar to the annual FFS schedule updates. What will be the procedure to follow for the CPT HCPC codes that providers can begin billing in January prior to AHCCCS fee schedule updates? Standard as it is now. Until a new rate is available new codes can be billed January 1st our new codes that become available during the year will be paid at the statewide Outpatient CCR.

Question HP: What if we get new technology that we want to address?

Sara: You can always negotiate. That is always within your scope.

Cia: We will pick those up. Some of the codes default if we don't have a rate. We don't want to let them sit for six months. It will default to CCR. The rate updates four times per year. January, April, July and October. For CMS new beds, we'll pick those up and if rate is available, we'll put that rate out. We have to have the codes available.

Mike: Anyting else?

Comment HP: We need to take a further look at the late charge process.

Mike: It is generally in agreement that we need to look at it further.

ACTION ITEM: Sara to look into late charge process further.

Comment HP: Concerned about the pharmacy because the markup is so significant. We have a lot of examples and scenarios that we've looked at where that pharmacy pricing goes to CCR-cost of charge ratio. Suggest that we establish a pharmacy cost to charge ratio.

Sara: We will take a look at that and see.

ACTION ITEM: Sara to look into establishing a pharmacy cost to charge ratio.

Question HP (Teleconference): Can you survey the Health Plans on how they will modify their own claims system? Whether they are asking their own software vendors for customization, whether they are going to a third party for repricing type software or are they planning to do this inhouse. Obviously we all have to make the changes that you are detailing.

Mike: We can do that.

ACTION ITEM: Survey to Health Plans on how they will modify their claims system.

Sara: We are going to send out a survey to all contractors regarding units. How you receive them and how you bill them to us. I haven't seen a draft yet and was hoping to have it today to share with you, but the questions that we really need to get to is because we have seen so many 1's on things that don't look like 1's. Part of our question is what is our contractor receiving from the hospital? Is the hospital truly billing just 1 unit at $43,000? Or, is the hospital billing whatever units and then the contractors system don't have anything to do with it just has to be a populated field right now on the encounter side for it to not pend. The system is just plugging along and lets it go through, and then we get the one that we have no idea what the units are. We are hoping that you are receiving the real true units from the hospitals, and then your systems are capturing it and giving it to us, but you have no reason to under the current system. We are going to have the sessions with the hospitals and adjust our FFS billing manual to assess units and explain units, but on the medicare side they are required to do some of the units fine-tuned. There are many things encouraging them to do so right now, but we are going to do a survey to see how many people fix them, have something in place or is just not reporting it as they receive it because it has not been a required field to report to us. That will be going out soon. We would like to know what you get from them. If everyone receiving only one unit from everyone, then hospitals are going to have a problem.

ACTION ITEM: Survey to contractors regarding units.

Question HP: Are you talking to the hospitals?

Sara: We have meetings with them. We have meetings scheduled throughout this whole process. We've had a hiatus while we have been rerunning the data, but this hasn't come up since we have been meeting with them from the last round, when we were January 1st bound.

Comment HP: Durable Medical Equipment will be a problem.

Sara: Why, because reporting is problematic?

Comment HP: It is grouped by revenue code?

Lori: Duly noted in DME there are certain areas that are problematic.

Sara: You'll be seeing that (survey) and please respond as requested.

Lori: The next meeting is currently scheduled for the 15th, which is only two weeks away. That's probably a little sooner than this group needs to get back together again. We have talked a little bit internally about, at least until things heat up and we get more into the testing phase, maybe going to a monthly meeting. Do we need to have it sooner? We don't want everyone to have to come and spend a lot of time here unless we've got enough information to share. So, would everyone be okay

with doing this in about a month? I'll get something sent out. We are also going to go to monthly meetings on the Consortium also, but they need their 9/15 meeting. They have some follow up items. We'll be a little off kilter for a while, and then we'll try and line them up so that if you are coming for one you can come for both. We will also offer all these meetings as a conference call, so we'll need to know if you want to do that. We'll try a little harder to make sure things are clear over the phone. It's kind of a learning process for us also, but we want to give you some options to make sure that as many people as possible can participate. I want to know if there is a preference for morning or afternoon, specific day of the week that doesn't work? Do you like Wednesdays?

Comment HP: Mondays are bad.

Lori: I will get that scheduled. Is there a preference morning or afternoon.

Comment HP: Morning.

Lori: I will get that scheduled. Anything else?

ACTION ITEM: Lori to schedule next meeting.

Question HP: As you come across questions, can you share them with us?

Lori: I made a note to work with Dora on summarizing the action items and coming up with a status report that we can do on a routine basis. We'll send it to you, whether or not there has been a resolution, so that you'll know what the running tally is. We've started doing this last meeting for the Consortium. It helps us to remember if we've told you things also. If we are gone for a month or six weeks it is diffucult to say "didn't we talk about that?"

ACTION ITEM: Lori/Dora to provide action items and/or questions to share with plans.

Lori: Anything else? Thank you all of you for coming or calling in.